Banner University Family Care

Written Consent to Appeal Form

In accordance with the State and Federal appeal regulations for Medicaid, **appeals filed by a provider on behalf of a member, must be accompanied by written consent from the member.** Please complete this form and return to Banner – University Family Care/ACC.

Member Name	
Member ID#	
Member's Date of Birth	
Provider Requesting Appeal	
Denied Authorization Number/ Description of Appeal	
Date of Notice of Action *(Letter)*	

I, _____, give my consent to allow Banner – University Family Care/ACC to process the appeal submitted by my provider, _____. Please discuss any aspects concerning this appeal with my provider, which may include disclosing confidential medical information, as needed.

Signature: _____ Date: _____
(Member / Authorized Representative)

Please email, fax, or mail this form to:
Banner – University Family Care/ACC
5255 E Williams Circle, Ste 2050
Tucson, AZ 85711
Toll-Free Fax 866-465-8340 | Local Fax 520-874-3462
BUHPGrievances&Appeals@bannerhealth.com

For questions, call our Customer Care Center at 800-582-8686, TTY 711.

Sincerely,

Grievance and Appeals Department
Banner – University Family Care

ATTENTION: If you speak English, language assistance services, at no cost, are available to you. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。**800-582-8686, TTY 711**
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